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The Problem of Transforming Post-War Planning Activities on Rural Health and Sanitation Into Definite Plans of Action

Kenneth E. Pohlmann

Today's session of the Regional Post-War Planning Committee (Southeast) has been exceptionally fruitful. We have really learned something about the health problems of rural peoples in this area. Mr. Montgomery's paper on the experimental health program in Newton County, Mississippi, has revealed both the strengths and weaknesses of voluntary plans for all farm families. Dr. Mott's frank discussion of the Farm Security Administration experiences in bringing health services to low-income farm families has also been illuminating. Again, we have learned something about the present poor status of health facilities and services in this Region, as compared not only with other sections of the country, but also with minimum standards laid down by reputable national professional organizations. Mr. Young's discussion of farm incomes in the Southeast and their relationship to the cost of medical care has given us some idea of the problems we must face if we are to reverse a downward trend in health services and facilities which has been underway for years. We have also received from the talk by Dr. Wm. H. McCaslan, of the Alabama State Medical Association, some idea of how the medical profession in one state is going about to correct many of these difficulties.

However, all of these discussions with the exception of that of Dr. McCaslan, have only served to pose real problems to this group without offering definite plans of action whereby these problems can be solved.

Unfortunately the various State Committee reports on health and sanitation were not discussed at this meeting. The evidence which they have revealed is already familiar to most of you and only bears out the often expressed statement that rural health facilities and services, uniformly weak throughout rural United States, are probably as poor in the Southeast as anywhere else. In some of our more prosperous agricultural areas these lacks may be met, in part, in the immediate post-war period through the ability of their general population to underwrite the cost of expanded facilities and services. There has been little evidence presented by any of the groups represented here today to indicate we may look forward to a similar happy solution to the problem here.

What then must you do to get at this problem here in the Southeast? First of all, you have got to recognize that its solution cannot be brought about by any one group alone. You need the counsel and advice of the organized health professions--the physicians, dentists, and nurses; you must have the broad vision and the labored experience of your state health and welfare agencies; and to these you must add the willingness of your rural and urban leaders to see the job through. But all of these are not enough. Do not overlook the need to enlist

the support of large segments of the public in your plans because any program, even though you think it is designed in their interest, cannot be imposed upon them. It must come in response to their expressed needs for it.

Dr. McCaslan has pointed up one aspect of the problem here today in his discussion of a regional system of hospital facilities. I should like to suggest several other aspects of the problem which need to be fully explored. For example, the work of state, district, and county public health departments, especially in the Southeast, in meeting health needs has already met with wholehearted public support. As time goes by it is bound to play an increasingly more important role in the daily lives of our people.

Someone has said that the public health of the future will be medical care. While many of you may not subscribe to that view, it is imperative that you understand the role of public health in the field of medical care. The necessity for coordinating essential public health services with the diagnostic and therapeutic services rendered by the medical profession, through such an augmented hospital system as is proposed by Dr. McCaslan, is only apparent to a limited group of experts today. Nevertheless, if we are to plan for an integrated attack on the health problems of our people we must face this task of coordination and must re-evaluate the present relationships between public health and private practice. Heretofore, we have been inclined to look upon the health officer, the sanitary engineer, and the public health nurse as responsible for a small segment of our health needs--in many instances giving them the responsibility for handling the unremunerative aspects of medical care and those categories of care which have been more readily susceptible to mass treatment, such as immunizations and the like.

It is high time we recognized the importance of this tax-supported health service as a factor in community life. The general scope of its work, the efficiency of its operations, and the relatively high volume of beneficial services which have resulted from its program in many areas are major accomplishments in the field of health.

We are prone to believe that the promotion of the health interests of our people has been confined largely to professional groups. However, a little investigation will reveal that the efforts of rural pastors, women's club leaders, farm organization leaders, racial groups, and others to improve health conditions have been important factors in making steady progress along these lines. Many rural communities owe the health facilities they now enjoy largely to the vision and generosity of public-spirited citizens who recognized a need and did something about it. The development and extension of public health facilities in many states has been due, in large measure, to the effective leadership of rural and urban lay citizens who concerned themselves with the health problems of their fellow citizens. This same leadership exists

in every village and hamlet in the Southeast and needs only to be mobilized to set in motion the machinery which will bring about necessary improvements.

Let us not lose sight of the plain folks--on the farm, in the factory, or in the mine--in our planning for action. They will decide whether or not such health plans as we make shall be supported. Too often the planners fail to take them into account when they are doing their planning. We would do well to acquaint them from the very beginning with the problems before we ask their support for proposed solutions. Otherwise they might very well dissappoint us when it comes time for getting their support to carry a program through.

The question arises as to what you can do about this whole matter. It is my frank opinion that you are in a key position to stimulate and encourage the citizens of the Southeast, through their community and other organizations, to develop a plan of action which will really get to the basic health problems common to every state in this region. Each state agency represented here today is able to play an important part, because of its special place in the lives of rural folk, in the development of any plan of action. It is true, as someone here has suggested, that you will need the cooperation of organized medicine to get the job done, but you cannot sit back and expect them to do it alone. It will require the support and cooperation of state agencies, rural and urban leadership, and the general public to develop a really significant program intended to bring the benefits of modern medicine to every citizen. Let us not lose sight of the fact that the public, since it foots the health bill, has a vested interest in health.

Post-war planning for rural health and sanitation here in the Southeast needs to be translated as quickly as possible into an action program. There is no time to lose. Already the Congress of the United States has under consideration a bill (S 191--the Hospital Construction Act) which would authorize expenditure of federal funds for extensive construction of hospital and related facilities. It was introduced by Senators Hill of Alabama, and Burton of Ohio in response to recognized needs. This measure should be studied, not alone by representatives of organized medicine and state health departments, but also by community leaders and broad groups of citizens.

The expansion of social security benefits to include medical care, as provided in the Wagner-Murray-Dingell bill in the last session of Congress, has been the subject of much bitter controversy and misunderstanding. Very little attempt has been made to present both sides of this important issue to the public in an impartial way. Health insurance proposals, both voluntary and compulsory, need careful study and consideration by many groups of people to the end that whatever arrangements are eventually worked out will assure every citizen, regardless of his status, the best that modern medicine can offer.

It seems to me that inactive State Subcommittees on Health and Sanitation need to be replaced by active committees made up of persons who are not only sympathetic to the problems which must be met but who also have some understanding of their significance and their implications. These Committees need to possess sufficient initiative and imagination to work out ways and means of building an informed public opinion, concerning these problems and proposed solutions. It is quite probable that some of your State Sub-committees have gone as far as they can go and that it is now time to establish some other medium for getting the job done.

It is suggested in those cases where State Sub-committees do not wish to carry their planning activities over into the field of action, for one reason or another, that there be established some other organized effort to carry on this essential work. The job cannot be accomplished by any one group alone. As I have said before, there needs to be broad representation from many groups in any organized attempt to cope with the health problems which exist here in the Southeast. Any plan of action which is to secure the support of the people must develop out of their knowledge of the problems and of proposed methods by which they can be solved.

It is possible that in each state a Health Conference Committee should soon be established, made up of representatives of membership or community organizations which have branches or chapters throughout the state. (For example, the Farm Bureau, The Grange, PTA's, Federated Women's clubs, American Legion, Veterans of Foreign Wars, Home Demonstration Clubs rural church organizations, trade unions, racial groups, etc.) Broad representation is imperative—the problem demands it. The initial selection of the members of this committee might be made by the State Sub-committee Chairman, in consultation with the Regional Activity Leader for Rural Health and Sanitation. The initial meeting of the committee could be called by the Sub-committee Chairman at the convenience of a majority of the members. At this meeting it would be well to have the Regional Activity Leader act as Chairman.

(It is suggested that prior to the first meeting of this committee, the Sub-committee Chairman and the Regional Activity Leader prepare an agenda for this meeting in order that the members may become acquainted with some of the problems and thus use their time in constructive work. Each committee member should also be provided with basic facts on the health situation in his state. They should also be furnished with suitable information on the subject matter to enable them to inform themselves intelligently on the general problems to be dealt with. They should also know something about proposed solutions. It is recognized that this will require careful planning and considerable effort on the part of both the Sub-committee Chairman and the Regional Activity Leader in preparation for this meeting, but it is very important that this first meeting get off to the right start.)

The contributions of organized medicine and the state health and welfare agencies should be primarily of an advisory nature throughout the planning and conference stages. The leadership of these organizations, especially if they are in constant touch with the organized professions, and the state health and welfare agencies, can accomplish much in the planning process. There must be mutual trust in the motives of each group. It is recognized that professional groups have much at stake in any plan of action which is developed, but it cannot be denied that the public in view of the alarming status of health facilities and services in the Southeast also has vested interest in the problem.

The first meeting should probably be taken up with a discussion of the report made by the State Post-War Planning Sub-committee on Health and Sanitation or, lacking such a report, by a discussion of the needs for health and sanitation in the state. The many problems involved should be discussed rather fully and a plan of action should then be prepared. This plan of action should be submitted back through the individual committee members, to their respective organizations, at both the state and local levels, for a thorough review and criticism. Suggestions from the local groups should be carefully weighed by members of the Committee at a subsequent meeting before they prepare a final draft.

The final plan of action drawn up by the Health Conference Committee should be presented to a called conference of representatives of the various membership and community organizations throughout the state. It may be necessary to have a series of such conferences in various sections because of travel restrictions, but the plan of action should be discussed and approved by delegates representing local groups so that it may have the necessary support at the local level.

After the committee has secured approval of the plan of action through a called conference, or series of conferences, it should be presented to the Governor, or any other appropriate state agency, with a request that legislative or other necessary steps be taken to implement it.

The Health Conference Committee should remain active and in touch with local groups until such time as a plan of action suitable to the membership organizations has reasonable assurance of being developed.

(A suggested agenda for the health conference committee meetings as well as for the rural health conference is attached.)

PROPOSED AGENDA FOR CALLED CONFERENCE

Morning Session

1. Purpose of Conference — State Chairman

   a. to discuss plan of action.
   b. to determine ways and means for implementing plan of action so that it may be carried through.

2. Discussion Panel - "The Plan of Action" — Chairman: Regional Activity Leader

   One representative each from the State Medical Society, State Hospital Associations, the State Health Department, the Department of Public Welfare, four representatives of the Health Conference Committee

Noon Luncheon

What We Did About the Health Problems in My State - (Clarence Poe, Elin Anderson, C. Horace Hamilton)

Afternoon Session

Discussion Panel - "Getting the Job Done" — State Chairman

1. A spokesman for each organization represented in the conference should outline the steps his organization will take to promote the plan of action.

2. Resolution or Recommendations of the Conference on the plan of action should be prepared and approved for submission to appropriate authorities.

3. Continuing Conference Committee to be elected and its powers defined.

PROPOSED AGENDA FOR
HEALTH CONFERENCE COMMITTEE MEETING

Morning Session

1. Purpose of Conference — State Chairman (15 minutes)

   a. to examine the evidence
   b. to listen to the testimony
   c. to formulate a program of action

2. Election of Committee Officers and Continuing Committee

3. The Problems of Health in Blank State as We See Them — Chairman, Regional Activity Leader (20 minutes on ea. problem by the best qualified person on that subject. 10 minutes between ea speaker for discussion from the floor)

   a. Facilities
   b. Public Health
   c. Personnel
   d. Quality
   e. Payment

Noon Luncheon

Guest Speaker - Federal-State Relations in Meeting the Health Problems of Blank State. (by someone who has a broad national view and who can relate it to the morning discussion - Michael M. Davis of Survey Graphic, for example.) — Chairman - A Comm. Member

Afternoon Session

1. A Yardstick for Measuring any Plan of Action to Meet Health Needs:
   (The ten point analysis - pages 76 to 79 Medical Care and Health Services for Rural People - Farm Foundation) — Regional Activity Leader (30 minutes)

2. The Conference Committee should then constitute itself as a working committee to formulate a tentative plan of action. — Chairman - Regional Activity Leader

3. Plans for Next Step and Future Meeting.

4. Adjournment

Form FHA-86
11-19-46

FDI 874

United States Department of Agriculture
FARMERS HOME ADMINISTRATION

REPORT ON RETURNED CAREER-SERVICE VETERANS NOT PROMOTED TO HIGHER GRADE SINCE THEY ENTERED THE ARMED SERVICES

Location _____ Period covered by report _____

Name A	E.O.D. Mil. Serv. B	Date Ret'd to Dept. C	Reasons and Contemplated Action D

Date: _____ _____

REPORT ON VETERANS HAVING RETURN RIGHTS
AND OF AVAILABLE POSITIONS

Region No. and Location _____ Month of _____

Grade	Total No. furlo'd or separated to enter Armed Forces	Total No. actually returned to duty in FSA	Total No. known to have been killed while in Armed Forces	Total No. released from the Armed Forces but not returning to FSA	Total No. employees still to be returned	No. Obsolete positions from which these employees left	No. of budgeted positions during this reporting period
A	B	C	D	E	F	G	H
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Total							

Remarks:

DIRECTIONS

A - This column gives the grades of the positions of the employees to be reported upon. In the other columns report the persons on the proper line for the grade in which their positions are classified.

B - In this column report the total number of employees (both men and women) who have been separated for military service or who were placed on military furlough. This figure should include everyone who entered the armed forces who has or might have return rights to a position by reason of such service.

C - In this column report the total number of employees included in column B who have actually returned to duty after military service by return from military furlough or by reemployment after military service. Report only those upon whom fanfold action has been taken.

D - In this column report the total number of employees included in column B who are known to have been killed in action or to have died while in the service. Report only those upon whom fanfold action has been taken.

E - In this column report the total number of employees included in column B who are known to have been released from the armed forces but who are not returning to FSA. This includes persons transferred to other regions or other agencies, who resigned after discharge from the armed forces, or who are not returning to FSA for any other definitely determined reason. Report only those upon whom fanfold action has been taken.

F - In this column report the number of employees included in column B who have not been eliminated by being included in columns C, D, or E. In other words, the total of this column should equal the total of column B minus the totals of columns C, D and E. If it does not, explain the circumstances under Remarks.

G - In this column report the number of positions from which the employees reported in column F were furloughed or separated and which have since become obsolete.

H - In this column report the number of positions which are budgeted during this reporting period.

In reporting, place the number of persons on the line representing the grade of the positions they left. For example, if you have 5 persons reported in column D who are known to have been killed in action, two of which are P-2 and one CAF-5 and two in Grade CAF-7, you will report two on the line for P-2, one on the line for CAF-5 and two on the line for CAF-7. They will also be included in the figures on these lines in column B.

Please total the columns. The figure reported as the total for column F should be the same as the total of column B minus the totals of columns C, D and E. If there is any reason why these columns do not verify in this manner, please explain the circumstances under Remarks. Also, if you have any special or problem cases which do not readily fall into the reporting procedure outlined above, explain them under Remarks.